HC-One Limited

Lavender Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The home requires a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. There is a manager who started working in this role in February 2014. This person is not yet registered with the Care Quality Commission. The manager has submitted their application to become registered with us.

Summary of findings

Lavender Lodge Nursing Home is a home that provides nursing care for up to 68 people who are frail or have dementia. People may need care for a period of time to recover from illness or have lived in the home on a longer term arrangement. At the time of our inspection 60 people were using the service. This was an unannounced inspection.

The service was not always caring. This showed in the way that some people with dementia were spoken to, were helped to move around, were supported to be independent and make some choices.

People's care were not always planned and delivered to ensure their emotional needs were consistently met. Plans were not always put in place to prevent people with dementia from becoming distressed or to enhance their quality of life.

There were limited social opportunities for people who were nursed in bed or had dementia. People who found it difficult to initiate contact might not always get the support they needed to prevent them from getting bored or lonely.

The provider had identified some of the concerns we found in relation to the quality of care provided to people with dementia. The manager however had not been aware of the concerns highlighted by our mealtime observations. Though the provider had plans in place to ensure people with dementia received safe quality care, some of these plans were still to be implemented and we could therefore not judge at this visit whether they would bring about the required improvements.

People were supported to stay healthy and eat and drink enough. They received good quality nursing care consistently in line with national clinical practice guidelines. Staff were trained and supported to understand the needs of the people they supported.

People and their relatives were encouraged to plan their own care. Where people did not have the capacity to consent to their care, arrangements were in place to ensure consent was sought lawfully and protected people's rights. We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

The home was providing safe general nursing care. Systems were in place to identify, report and respond to safety incidents appropriately and action was taken to prevent these incidents from re-occurring. People and their relatives told us they felt safe in the home and when receiving care.

The manager reviewed all safety incidents as part of the home's quality assurance process and had taken action to reduce the occurrence of chest and urine infections. The organisation also monitored the performance of the home and was supporting the new manager to develop their skills and make improvements to the home.

People and relatives were encouraged to give their views about the home and their feedback was used to make improvements.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was delivering safe care. People who used the service and their relatives said they felt safe in the home and when receiving care.

When people needed assistance, this was provided promptly and there were enough staff to meet people's needs.

People were protected from abuse. There were good systems in place to manage risks associated with individual's healthcare needs. People were supported to make informed choices which included taking risks. People were involved in developing their own safety plans. Systems were in place to learn from incidents. When a risk to a person's safety did occur, staff reported it promptly and appropriate action was taken to prevent incidents from re-occurring.

Is the service effective?

Good

The service was effective. Staff were skilled and received comprehensive training to ensure they could meet the needs of the people they supported.

People's health care needs were assessed and staff supported people to stay healthy. People had access to health professionals when required and were supported to eat and drink enough to meet their needs.

Nursing protocols were based on national clinical practice guidelines. For example, in relation to wound and diabetes care and ensured people received effective nursing care.

Is the service caring?

Requires Improvement

The service was not always caring. Some staff supported people to make their preferences and wishes known. However, people with dementia did not always receive the support they needed to make choices and be independent. When helping people to move, staff were not always respectful. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service responsive?

Requires Improvement

The service did not always respond to the needs of frail people and those with dementia. Systems primarily accommodated the social needs of people who could express their social preferences and engage with activities.

People who found it difficult to initiate contact were at risk of not having the support they needed to prevent them from becoming bored, lonely or distressed. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

People and their relatives told us they would feel comfortable about complaining to staff if something was not right. When people did complain the home thoroughly investigated their concerns and tried to put things right.

Is the service well-led?

Requires Improvement

The provider had identified some of the concerns we found in relation to the quality of care provided to people with dementia. The manager however had not been aware of the concerns highlighted by our mealtime observations. Though the provider had plans in place to ensure people with dementia received safe quality care, some of these plans were still to be implemented and we could therefore not judge at this visit whether they would bring about the required improvements.

The new manager was a strong leader and was working at building trust in the home by encouraging open and honest communication between people, professionals, staff and relatives.

Systems were in place to review safety incidents and audit performance so the home could identify any themes, trends or lessons to be learned. The manager had taken steps to reduce the occurrence of chest and urine infections in the home and the risks associated with falls were well managed

Lavender Lodge Nursing Home

Detailed findings

Background to this inspection

We inspected the home on 6 August 2014. We spoke with 12 people who lived at the home, five relatives, six care workers, two nurses, two housekeeping staff and one maintenance person. We attended the 8am shift hand over meeting and the 2pm unit managers meeting. We spoke with the home manager and the quality assurance manager. We reviewed people's care files, staff training records, a selection of policies and procedures and records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spend time observing how staff care for people on all three floors and especially on the Jasmine floor where most of the people with dementia were being cared for.

The inspection team consisted of two inspectors and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the visit we looked at previous inspection reports and notifications that we had received. Services tell us about important events relating to the care they provide using a notification. We also reviewed the Provider Information Return (PIR) from the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At our last inspection in September 2013 we did not identify any concerns. Following our visit we sought feedback from commissioners and health care professionals to obtain their views of the service provided to people.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People told us they felt safe and supported by staff. Comments included ‘‘I feel safe living here’’ and ‘‘There are always staff when you need them’’. People also felt safe because they said they knew staff would come quickly when they called for help. Call bells were answered promptly. Where people could not use their call bells to raise the alarm staff checked on them at least hourly or more often if needed to make sure that they were safe. One relative told us ‘‘I have spent a lot of time here recently and the nurse comes to check on my relative at least every hour.’’

The number of staff needed to safely meet people’s needs had been assessed by the manager. People said that there were always staff to support them when needed. Staff told us they felt there was sufficient numbers of staff on duty. One staff member said that an additional member of staff on occasions would enable them to spend more one to one time with individuals on specific activities. One person told us ‘‘there is always someone available if I need them.’’ We saw that staff attended to people promptly. Staff told us although they were rushed at times, people’s needs were met. The quality assurance manager told us that they were involved in reviewing the number of staff on duty to ensure it was adequate. Additional staff were used if people’s needs increased.

Care staff provided the majority of support and care to people. They kept the nurses, managers and relatives up to date when people’s needs changed. We saw evidence of this in records. We attended the 8am shift handover meeting during which a nurse highlighted all incidents that had occurred during the night and communicated changes in people’s needs. The nurse provided additional instructions to care staff to help them support people appropriately and safely.

Arrangements were in place to ensure people were protected from abuse. Staff had received safeguarding training. They knew how to identify potential abuse and understood their reporting responsibilities. This was in line with the service’s safeguarding policy. Since our last inspection appropriate action had been taken by the manager to gain support for one person who was at risk of harm from others. A safeguarding plan was in place and this was being followed. The person was safe.

People were informed of the risks they were taking and supported by staff to take risks when this gave them increased independence and control while at the same time ensuring their safety. For example, one person was keen to continue to mobilise. During the handover meeting, staff discussed and agreed how best to support this person so they were as safe as possible, whilst they built their confidence when walking in the home.

The manager undertook a daily safety audit of the building and equipment to help prevent accidents or incidents happening in the home. They ensured people, relatives and staff were involved with this. For example, when the manager had been made aware of boxes restricting access to a fire escape this was immediately addressed. The boxes were removed and a sign put up to remind staff not to restrict passage ways. In addition, regular meetings took place which were used to raise any safety issues. We attended one meeting and heard issues being raised and actions being taken to maintain people’s safety. Incident reports showed that the home’s safety audit ensured that there was a low incidence of accidents or incidents relating to the building.

Each person had individualised risk assessments and management plans, completed with them and their relatives. Care plans informed staff how to reduce the risk of injury to themselves and to people. For example, the moving and handling plan for one person required them to be hoisted by two care staff. The risk assessment provided staff with instructions on how to undertake this task safely. Staff told us the information in care plans was sufficient to ensure they knew how to undertake tasks safely. Nurses were clear what their role was in managing clinical risks and monitored whether care staff were carrying out tasks safely. People and relatives told us that care workers undertook care tasks safely.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Care homes, in order to ensure people’s rights are protected, must make a formal application and have authorisation to impose restrictions on people. Care homes have to apply for authorisation when restrictions are imposed on people to keep them safe when they do not have the capacity to consent to these restrictions.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had completed training in the Mental Capacity Act (2005) (MCA)

Good

Is the service safe?

and DoLS and were clear on how this applied to their practice and people living in the home. Two people had a DoLS in place and care workers were informed of the authorised restrictions. The manager was awaiting the outcome of two more applications. Records showed the manager monitored and renewed the DoLS appropriately. Records showed that staff used the least restrictive action possible in order to keep people safe. Advice about how to keep people safe using the least restrictive method had been taken from appropriate sources such as mental health professionals.

Some people needed to use equipment to keep them safe, that could also be used as restraint, for example bed rails. Staff ensured these were used appropriately by carrying out risk assessments to show why they were needed. They also made sure that people understood the reason they were being used, and that people consented to their use.

Good

Is the service effective?

Our findings

People felt appropriately supported by staff. Comments included ‘‘staff are very good’’, and ‘‘they look after me so well’’. One relative told us ‘‘Staff are very good in the day to day things.’’

Nurses and care staff understood their various responsibilities in meeting people’s health and care needs. For example, when managing people’s wounds and monitoring their skin. Staff said people’s care plans and risk assessments gave them clear instructions on how to meet people’s health needs. Information in care plans and the nurses’ treatment protocols were based on national clinical practice guidelines. This meant when people received care, for example, wound care or support to manage their diabetes, this was done consistently and in line with national treatment and care recommendations.

Staff had completed appropriate induction and training when they started work at the home. The induction required new members of staff to work with more experienced staff to ensure they were safe and sufficiently skilled to carry out their roles before working independently. The induction formed part of a six month probationary period, so that the manager could assess staff’s competency and suitability to work in the home. We spoke with a new care worker who confirmed they were being observed and assessed by experienced staff whilst undertaking care tasks over four days.

Staff told us they had received enough training to meet the needs of the people they supported, and records confirmed this. Comments included: “I feel I have learnt more from working with other staff than from the e-learning we do’’ and ‘‘we do a lot of training’’. Care workers and nurses completed training that was specific to the needs of people living in the home. This included falls awareness, dementia care and promoting healthy skin. Nurses had guidance to support them to undertake their clinical tasks effectively in line with the home’s procedures. This included wound and falls management. Staff also completed training in safeguarding adults, the Mental Capacity Act (2005) and DoLS, understanding and resolving behaviours that could harm people and safe moving and handling.

The specialist community nurse for nursing homes told us ‘‘staff are really very competent. I worked with them supporting someone at the end of their life recently and they did a brilliant job in ensuring my guidance was implemented. They have also supported a new resident over the past five weeks and there has been a massive improvement in their general health.’’

Staff received ongoing individual meetings with their supervisors as well as regular appraisals. This enabled staff to feel supported in their roles and to identify any future professional development opportunities. Staff confirmed that they felt supported by the manager, the nursing staff and the wider team. Staff commented: “the manager is very approachable, she knows the residents well and can give good advice’’ and ‘‘we work well together and help each other out.’’ The manager had introduced a new competency assessment for nurses to use when judging care workers’ skills. They told us ‘‘A lot of the training is e-learning and I needed the nurses to observe staff to see if they know how to undertake their tasks and what support they need.’’

Staff supported people to stay healthy and people’s care plans described the support they required to manage their day to day health needs. The plans included information about people’s personal care, skin management, catheter care, falls prevention, medication and mouth care needs. Care plans also noted the support people required to manage their mental health. Records showed that people had regular access to healthcare professionals such as GP’s, chiropodists, opticians and dentists.

Three people were receiving wound care and were at risk of developing pressure sores. They had risks assessments and management plans in place. These detailed the care duties nurses and care staff had to complete to ensure each person’s skin remained healthy. Daily records were kept of how much people had to drink, skin checks and wound dressings to support the nurses and manager to monitor whether care was being provided appropriately. The manager monitored the effectiveness of all wound treatment across the home monthly and requested specialist support from the tissue viability nurse or GP when required.

People with diabetes had their blood sugar levels monitored to ensure their health was maintained. Any concerns were raised and GP’s were contacted. Nurses had identified one person was at risk of unstable blood sugar because they were not eating and drinking. We saw a clear plan to manage this and to reduce the risk of them becoming unwell. The plan included the signs of ill health

Good

Is the service effective?

that staff should look for and the actions nurses should take. The person also received specialist foot care and GP services. We spoke with the chef who told us they had received training to support them prepare appropriate food for people with diabetes. They told us, "We don't always have to provide an alternative. If you give one person a really nice cake, and the other has something else, it can be uncomfortable. I went to training with a nutritional specialist, they said people can have what they want, but often a smaller portion."

Some people were at risk of malnutrition, and staff took appropriate action to manage this. People's weight was monitored and action taken if they were not maintaining weight. Some people had their food intake recorded and monitored to ensure they were eating enough. Some people had fortified foods (food where the amount of calories is increased through the addition of cream and cheese) and fortified drinks (prescribed drinks used to increase people's calorie intake).

People said they enjoyed the food. Kitchen and care staff had good knowledge about the foods people liked and didn't like. One person's comment summed up the general feeling ''the food is excellent and if I don't like something they make me something else''. One care worker confirmed ''we are very flexible with meal choices especially with some of our residents with dementia that lose their appetites. If we know what they like we make sure they get it so that they can continue to eat well.''

The home was taking part in a NHS hydration project and had several hydration champions who ensured that people had enough to drink. They told us there were always drinks available for people. This was confirmed by people and relatives we spoke with. One relative said ''they made sure people were offered drinks in the hot weather. My wife had not had water infections since living in the home and she got them a lot.'' The manager told us that the home monitored the prevalence of urine infections across the home monthly and that there had been a significant decrease since the hydration project started. One professional told us ''the home really embraced the hydration project and have been working very hard to ensure people had enough to drink.'' The home had introduced coloured jugs as part of this project to support people with dementia that could associate the different colour jugs with the same coloured juice for example orange jugs were used for orange juice and purple ones for blackcurrant squash.

Staff supported people who had difficulty swallowing to eat safely. All staff had received training in the use of thickening agents and we observed them thickening food appropriately during lunch time.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were very respectful and caring. However, relative's experience of staff were mixed. One relative told us "All the carers are respectful and caring and treat my relative with love" and another said "they don't always interact with the residents."

Some people could not tell us about their experience of care because they had dementia. During our observation, which happened over lunch, we saw that people were not always supported in a manner that upheld their dignity, especially on the Jasmine care unit. Although people had enough to eat and drink, the way that food and choices were offered, was not always caring. People were given drinks without being offered a choice. One care worker asked a person five times whether they preferred pork or chicken. The person found it difficult to make a decision and eventually the care worker made the choice and the person was given a meal. The person had not been given visual aids, such as pictorial menus or shown plates of the two meals to support them to make a choice themselves.

People were not given the time to eat or supported to understand the meal time activities. One person was fed by a member of staff at a speedy pace and in silence. Food was put into another person mouth without the care worker explaining to them what was going to happen or what they were about to eat. This would be important to a person who might find it difficult to see, carry out a sequence of tasks or judge distance. Assistance to people who had difficulty eating was not offered discreetly. Bibs not serviettes were used to protect people's clothing and were put around people's necks without asking their permission or explaining to them what was going to happen. Finger food was not offered to people who have difficulty using cutlery or adapted crockery and cutlery provided to enable people to feed themselves where appropriate. One person struggled to use their cutlery and was left trying to pick food up from the floor with their knife. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also saw some staff interacting with people in a positive way. Some staff treated people with respect and supported them by giving them time to express their preferences and make choices. For example, when drinks were offered during the afternoon on the Jasmine care unit. People were given the opportunity to build relationships with staff because the home ensured that staff always worked on the same floor so that people could become familiar with them. Some staff knew people well and took time to chat and asked people about their day. One person kept a note book to help them remember, staff knew this and kindly reassured and encouraged them to use it. However, people were not always reassured and when another person became anxious calling out when staff were hoisting them, the two care workers did not comfort or explain to them that they were safe.

People were involved in decisions about their end of life care. For example, we saw one person had expressed a wish not to be resuscitated if their health failed and had an advanced care plan (a plan of their wishes at the end of life) in place. We saw the person and their family were involved in this decision and had already made plans for their funeral. Another person had a living will which stated they wanted their body to be used for scientific research. We saw that this request was clearly noted in the person's advanced care plan.

The home ensured that relatives were kept informed of people's failing health and we heard examples of how relatives were supported to spend more time with people including having lunch with them in a private part of the dining room. One nurse told us "this is precious time for people and their family and it is important that they create as many memories as they can." At the time of our inspection there was no–one receiving end of life care. A health professional told us "they supported me with a person's end of life care recently. I couldn't fault them they were kind, caring and sensitive to the person and family". The family had received a personalised gift from the home and two staff members had attended their funeral.

Requires Improvement

Is the service responsive?

Our findings

People's care were not always planned and delivered to ensure their emotional needs were consistently met. Plans were not always put in place to prevent people from becoming distressed or to enhance their quality of life. Some people with dementia could become anxious, for example, when the fire alarm test was taking place because they did not understand what was happening. Although staff were encouraged to talk with people, they did not recognise this person had become anxious and we had to request support for them. There was a lack of personalised information in people's care plans about what to talk to people about because information and events which might engage that person and help them to become less anxious was not available. For example, one person's care plan noted that they were often anxious and liked to talk to people. Information was not available for staff to know how to reassure this person and actively create social opportunities for them. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's need to engage in meaningful activities to maintain their social skills had been assessed. However the activities offered to people in the home on the day primarily accommodated the needs of people who could express their social preferences and engage with activities with minimal support.

Activity co-ordinators delivered a variety of activities daily in the downstairs lounge and people from the other two floors were encouraged to attend. Although staff told us activity co-ordinators spent time with people on the other two floors we did not see this happen during our inspection. We observed that people who found it difficult to initiate contact were given very little time and attention throughout the day. One person was nursed in bed and had difficulty communicating. Their care plan did not indicate how staff were to support them through alternative means of communication, such as touch, to remain engaged. Relatives told us that they felt there were not sufficient social opportunities for people with dementia. Comments included ''they could have a memory café or an activity box'', ''some people seem bored, there is no stimulation for them'' and ''there is nothing for my relative to do all day''. We could not determine whether this might have been people's preference's as it was not clearly stated in care plans and some people who were at risk of loneliness and boredom might not receive the support they required.

The home identified when some people's mood or behaviour changed and could potentially put them or others at harm. They took prompt action by involving relevant mental health professionals like psychiatrist and community mental health nurses. Care plans reflected professional guidance and staff could describe how they would support people's to maintain their mental health.

People who used the service, and where appropriate their relatives or representatives, had been involved in the care planning process. People's needs had been assessed and care plans were in place. The home had introduced a 'resident of the day' project in June 2014. This meant every month named people received an in depth review of their care so that the home could ensure their care plan reflected what was important to them. Relatives told us that they were encouraged to support people to plan their care. Comments included ''I have lots of chats with staff to discuss how we can get my relative to eat better'' and ''they involve me in all decisions because my relative can't make them anymore.''

People's care plans showed what was important to each person living at the home and it was treated as important information by staff when supporting people. For example, staff had recorded information about people's religious beliefs. One person practised their faith in private. Care workers described how they respected this person's wish and supported them when requested. People who took pride in their appearance and required assistance to maintain this told us they were supported, and were assisted if needed to visit the hair dresser. The hairdresser came to the home once a week and a wheel chair friendly basin was used to support people using wheelchairs to have their hair washed comfortably. Staff were creative and flexible when supporting people to manage their health. For example one person was struggling to stick to their diabetic diet. Staff worked with them and a plan was agreed to support the person with smaller meals and snacks to meet their dietary needs. The nursing staff worked with the chef to make this person's food appetising so that they would be encouraged to eat

People told us that they enjoyed taking trips outside the home and had asked the manager if more activities could

Requires Improvement

Is the service responsive?

be arranged. The home had purchased a minibus to enable people to go out more often and people were given the opportunity to attend activities outside the home three times a week. Resident meeting records noted that people wanted to ensure that everyone who wanted to go on a trip got a chance to go out. The home had put a system in place to enable people to take turns going out and trips were allocated fairly.

People's wishes to remain part of their family and maintain their friendships were respected and encouraged. Some relatives visited daily and the home had created seating areas for families so that people could spend time with families outside of their rooms. Relatives were encouraged to take part in the home's activities and photos from a recent pub trip included several relatives. Relatives and friends confirmed that they were always welcome to spend time with people. Records showed that activities were discussed during monthly relatives meetings and relatives were given the opportunity to influence the activity plan.

The service was sensitive to the rights of people who did not have the capacity to independently make decisions about their care. Systems were in place to ensure that decisions about people's care were lawful and these were kept under review. The home had recently introduced a mental capacity screening protocol and nurses were reviewing the decision making capacity of people with dementia in line with this guidance. The manager undertook an audit to check the review had been completed. People could then be assured that capacity assessments and best interest decisions would be undertaken when indicated by the review. Some people had legal representatives to support them to make decisions about their care. Staff could explain the role of people's legal representatives and how they were involved in making decisions about people's care.

People knew how to make a complaint and the provider had an appropriate complaints policy in place. The policy provided information for people about how to make a complaint as well as the contact details of local advocacy services if people required support to complain. The manager had a positive view of complaints and told us ''a complaint is how we learn.'' The service had received two complaints in the past year which had been investigated by the home manager and the quality assurance manager in line with the complaints policy. The home checked if people were satisfied with the outcome of their complaint. Systems were in place to ensure that any actions identified following a complaint were implemented and also to learn how the service could improve the quality of care to all people. For example, following the two complaints a new sock system was introduced by housekeeping and all wheelchairs were clearly marked to ensure people had the use of their own wheelchairs.

Requires Improvement

Is the service well-led?

Our findings

The culture in the home was changing following the appointment of a new manager in February 2014. All the staff told us that the running of the home had improved and the new manager was committed to people, learning and improvement. The manager confirmed that they were working on building confidence in the organisation. They told us ''we have to build open relationships with honest communication so that people can trust us. They need to see that we want the best for people and will do what we say we will do.'' Relatives told us they were beginning to see improvements in the way the home was run. One relative said ''The management has improved enormously over the last few months, they are making changes for the better, new curtains, new flooring.''

Staff commented on the positive changes being made and told us they received clearer direction from management. For example, one nurse told us ''there are new supervision forms and other procedures which helps me understand what I need to do when supervising care workers.'' They also told us that there had been a lot of renovation and that a minibus had been acquired to take people out. Staff appreciated the manager's knowledge of the people in the home and told us ''her advice is always good, she knows people in the home well and her solutions are helpful. She is very practical and hands on.'' The manager had praise for the staff describing them as ''a very strong team'', ''very supportive'', ''very committed to the changes we need to make.''

The new manager understood the challenges the home faced and had plans to improve the quality of the service especially for people with dementia. They told us ''I have been focusing on the high risk areas first like getting strong clinical governance in place, getting some refurbishment done and establishing good communication. I now need to focus on establishing excellent care for people with dementia.'' They were reviewing all activities provided to people with dementia to ensure that they were appropriate. Plans included purchasing a portable sensory machine to be used in people's rooms and for the activity co-ordinators to undertake a care qualification. In addition, the provider's activity specialist would be visiting the home to recommend activities that could be delivered in the home to meet people's diverse needs. The manager told us that the physical environment needed to be adjusted to allow enough space for people with dementia to move about and were planning to create activity spaces for example a sensory garden, a quiet room, nail bar, coffee, tea and wine bar. They had submitted their plans to the provider and were awaiting their decision.

The provider was taking action to ensure that people with dementia were cared for by staff that understood how to support them with dignity and kindness. One nurse had been appointed as the home's dignity and dementia lead and would be completing further dementia training in November 2014. The manager told us ''we want to ensure that staff know how to implement their dementia knowledge and she will be supporting them to do this in a practical way''. Observations of staff undertaking their tasks had been introduced so that the provider could identify when staff required further training when interacting with people. They also continued to reinforce the Kindness in Care Award which celebrated the staff member or team that provided the kindest care every month as nominated by staff, people and relatives.

The provider had identified that the care plan format required review to ensure care workers had all the information they needed to support people with dementia. The manager had developed several documents in the interim to enhance the information in some people's care plans whilst the provider reviewed the care plan contents.

The provider had identified some of the concerns we found in relation to the quality of care provided to people with dementia. The manager however had not been aware of the concerns highlighted by our mealtime observations. Though the provider had plans in place to ensure people with dementia received safe quality care, some of these plans were still to be implemented and we could not judge at this visit whether they would bring about the required improvements. Therefore this was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvement was integral to the service and quality assurance systems involved people that used the service, and their relatives. Processes were in place to receive feedback from all stakeholders and included monthly satisfaction questionnaires, feedback cards, residents, relative and staff meetings. The manager had incorporated stakeholders' feedback about the home environment in their improvement plan and a refurbishment plan was underway. Meeting minutes confirmed that the manager

Requires Improvement

Is the service well-led?

used the monthly meetings to promote open communication by keeping people updated on improvements and using their feedback to measure the success of the changes that have been implemented. For example people had been excited about the community activities the home had offered and the manager was recruiting volunteers so that people could to go out more often. A newsletter was also being published from September 2014 as suggested by relatives so that they home could remain transparent with the improvements they were making.

The manager felt supported by the organisation to develop their leadership skills and improve the home. They were completing a manager's induction programme and were supported by the quality assurance manager who visited the service weekly. The quality assurance manager attended the unit manager's meeting on the day of our inspection so that people could be assured that the organisation was up to date and provided support to the manager to deal with the issues in the home.

Staff had clearly defined roles. They were given specific areas of responsibility for example managing the shift rota, mentoring new staff, leading a care shift or managing a unit. The manager told us they actively encouraged staff to take on lead roles so that service delivery became a shared responsibility and ''the team as a whole becomes responsible for delivering a really good service.'' Nurses told us they received support to develop their management skills to enable them to supervise care staff with confidence.

Systems were in place to review risks and learn from incidents to improve the safe delivery of people's care. The manager reviewed all reported incidents daily and shared concerns with unit managers to action. Clinical incidents were recorded and reported to the organisation monthly to ensure the manager monitored the effective delivery of nursing care. The manager used this information to monitor the quality of clinical care across the home. This included the auditing of falls, pressure sores, weight loss, and chest or urine infections. The manager had identified an increase in the occurrence of infections and had intensified the infection monitoring over the past few months. They told us ''I am very happy to see that our chest and urine infections are now low and we have really improved and managed these well.'' Falls were monitored through an internal monthly falls meeting and followed by an external fall's specialist visiting the home monthly to review and advice the home on their falls management practice. They told us ''I am very satisfied with the home. They keep the records I ask and have worked very hard at reducing people's risk of falling.''

The service had strong links with the organisation's learning and development team as well as external agencies which informed their practice. This had enabled them to take action to ensure they were compliant with the requirements of the MCA code of practice and DoLS.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used services did not receive care and treatment that met their individual needs. Limited activities were available to people with dementia. People who found it difficult to initiate contact were at risk of not having the support they needed to prevent them from becoming bored or lonely. Regulation 9 (1) (b) (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who used the service were not always treated with dignity. People who required assistance to eat were not given the time they needed to eat and the support to maintain their dignity during meal times. Regulation 17 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider had not identified all the risks relating to the delivery of care to people with dementia. Plans were in place to manage some of the risks but at the time of our inspection these were still to be implemented. Regulation 10 (b).